

Jump Start To Kindergarten
Health Care Professional Form

Child's Name: _____ Birthdate: _____

Address: _____ Phone: _____

Parent/Guardian Name: _____

Date of last physical exam: _____ How long has this child been a patient: _____

Does this child have any allergies (including allergies to medication)? _____

Is a modified diet necessary? _____

Is there any condition present that might result in an emergency? _____

What is the status of the child's:

Vision: _____

Hearing: _____

Speech: _____

Please list below any important health concerns: Indicate if you believe this concern requires special attention or accommodation at child care.

Medical concern: _____

Requires attention at child care: _____

Additional information? _____

Signature of Physician

Date